



TEPEZZA® (teprotumumab) Referral Form

RETURN COMPLETED FORM VIA FAX TO:
888.898.9113

PATIENT INFORMATION (Complete or fax existing chart)		PRESCRIBER INFORMATION	
Patient Name: _____		Prescriber Name: _____	
Address: _____		State License: _____ NPI #: _____	
City, State, Zip: _____		DEA: _____ Phone: _____	
Phone: _____ Alt. Phone: _____		Address: _____ Fax: _____	
DOB: _____ Gender: M F Last 4 SSN: _____		City, State, Zip: _____	
WT: _____ HT: _____ Allergies: _____		Contact Person: _____ Phone: _____	
INSURANCE INFORMATION - INSTEAD - just send us a copy of the patient's prescription / insurance cards (front & back)			
Primary Insurance: _____		RX Card (PBM): _____	
City, State, Zip: _____		BIN: _____ PCN: _____	
Plan #: _____		City, State, Zip: _____	
Group #: _____		Group #: _____	
Phone: _____		Phone: _____	
DIAGNOSIS/CLINICAL INFORMATION			
<input type="checkbox"/> E05.00 – Thyrotoxicosis with diffuse goiter without thyrotoxic crisis or storm			
LABORATORY DATA			
CBC: _____		BMP: _____	SEROLOGY: _____
OTHER: _____			
TEPEZZA® (teprotumumab) DOSING		REFILLS:	
<input type="checkbox"/> Tepezza® 10mg/KG at week 0			
<input type="checkbox"/> Tepezza® 20mg/kg q 3 weeks x 7 doses			
<input type="checkbox"/> Other: _____			
SIGNATURE			
X _____		DATE: _____	
Prescribing Physician Signature			

To ensure payment by insurance carrier, please include supporting clinical documentation for specified ICD 10 Code, demographic and insurance information along with faxed order. Initial appointment will be verified upon insurance approval.

Important Information: This facsimile transmission is intended to be delivered only to the named addressee and may contain material that is confidential, privileged, proprietary or exempt from disclosure under applicable law. If it is received by anyone other than the named addressee, the recipient should immediately notify the sender at the address and telephone number set forth herein and obtain instructions as to disposal of the material. In no event should such material be read by anyone other than the named addressee, except by express authority of the sender to the named addressee.

Thank you for choosing Talis Healthcare

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